		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0046201

Facility Name: Lemont Nursing & Rehab Center, Llc

Address: 12450 Walker Road (Number) Lemont (City) 60439 (Zip Code)

County: Cook

Telephone Number: (630) 243-0400 **Fax #** (630) 243-5063

IDPA ID Number: 383663760001

Date of Initial License for Current Owners: 02/01/03

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) Edward N. Slack, C.P.A.
(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015
(Telephone) (847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	158	Skilled (SNF)	158	57,828	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	158	TOTALS	158	57,828	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	24,690	14,528	12,827	52,045	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,690	14,528	12,827	52,045	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.00%

D. How many bed-hold days during this year were paid by Public Aid? 1 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/03

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/03 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 12,709

Medicare Intermediary Riverbend Government Benefits Administrator

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	287,085	50,243	12,076	349,404		349,404	(1,943)	347,461			1
2	Food Purchase		224,710		224,710		224,710	3,174	227,884			2
3	Housekeeping	133,736	31,555		165,291		165,291	(5,538)	159,753			3
4	Laundry	56,014	23,988		80,002		80,002	(2,153)	77,849			4
5	Heat and Other Utilities			137,426	137,426		137,426	1,301	138,727			5
6	Maintenance	116,952	43	196,938	313,933		313,933	6,016	319,949			6
7	Other (specify):*							1,749	1,749			7
8	**TOTAL General Services**	593,787	330,539	346,440	1,270,766		1,270,766	2,607	1,273,373			8
	B. Health Care and Programs											
9	Medical Director			35,000	35,000		35,000		35,000			9
10	Nursing and Medical Records	3,013,885	176,257	340,466	3,530,608		3,530,608	(1,958)	3,528,650			10
10a	Therapy	115,045		157	115,202		115,202		115,202			10a
11	Activities	144,899	29,884	2,173	176,956		176,956		176,956			11
12	Social Services	146,183		4,340	150,523		150,523	9,356	159,879			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							5,164	5,164			15
16	**TOTAL Health Care and Programs**	3,420,012	206,141	382,136	4,008,289		4,008,289	12,562	4,020,851			16
	C. General Administration											
17	Administrative	86,057		7,975	94,032		94,032	11,957	105,989			17
18	Directors Fees											18
19	Professional Services			263,524	263,524		263,524	(144,439)	119,085			19
20	Dues, Fees, Subscriptions & Promotions			30,552	30,552		30,552	(7,194)	23,358			20
21	Clerical & General Office Expenses	92,546	24,841	337,007	454,394		454,394	(141,155)	313,239			21
22	Employee Benefits & Payroll Taxes			651,192	651,192		651,192	(5,018)	646,174			22
23	Inservice Training & Education			933	933		933		933			23
24	Travel and Seminar			1,297	1,297		1,297	3,516	4,813			24
25	Other Admin. Staff Transportation			1,647	1,647		1,647		1,647			25
26	Insurance-Prop.Liab.Malpractice			148,725	148,725		148,725	759	149,484			26
27	Other (specify):*							20,214	20,214			27
28	**TOTAL General Administration**	178,603	24,841	1,442,852	1,646,296		1,646,296	(261,360)	1,384,936			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,192,402	561,521	2,171,428	6,925,351		6,925,351	(246,192)	6,679,159			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc #0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			20,061	20,061		20,061	135,081	155,142			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			519	519		519	189,329	189,848			32
33	Real Estate Taxes			252,581	252,581		252,581	1,607	254,188			33
34	Rent-Facility & Grounds			465,744	465,744		465,744	(457,004)	8,740			34
35	Rent-Equipment & Vehicles			9,043	9,043		9,043	1,566	10,609			35
36	Other (specify):*							19,534	19,534			36
37	**TOTAL Ownership**			747,948	747,948		747,948	(109,887)	638,061			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		607,456	831,114	1,438,570		1,438,570	(30,431)	1,408,139			39
40	Barber and Beauty Shops			39,025	39,025		39,025	(39,025)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			86,742	86,742		86,742		86,742			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		607,456	956,881	1,564,337		1,564,337	(69,456)	1,494,881			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,192,402	1,168,977	3,876,257	9,237,636		9,237,636	(425,534)	8,812,102			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(185)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(59,046)	30		9
10	Interest and Other Investment Income	(33,805)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(616)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(126,600)	21		24
25	Fund Raising, Advertising and Promotional	(9,415)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(210)	20		28
29	Other-Attach Schedule	(213,552)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (443,429)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	17,895		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 17,895		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (425,534)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Lemont Nursing & Rehab Center, Llc

ID# 0046201

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Out of Period Legal	$ (66)	19	1
2	Other Income	(76)	21	2
3	Patient Clothing	(325)	10	3
4	Barber and Beauty	(39,025)	40	4
5	Theft Loss	(1,373)	21	5
6	Collection Expense	(1,369)	21	6
7	Bldg Co - Bank Charges	(86)	21	7
8	Bldg Co - Amortization of Goodwill	(31,371)	36	8
9	Bldg Co - Filing Fees	(250)	20	9
10	Bldg Co - Replacement Tax	(3)	21	10
11	NonAllowable Expense	(139,808)	21	11
12				12
13				13
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98				98
99				99
100				100
101	Total	(213,552)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(79)	341		3,106	(5,311)				(1,943)	1
2	Food Purchase	(801)							3,975				3,174	2
3	Housekeeping				(5,538)								(5,538)	3
4	Laundry				(2,153)								(2,153)	4
5	Heat and Other Utilities					1,301							1,301	5
6	Maintenance				(27)	1,389		4,633	21				6,016	6
7	Other (specify):*						326	1,132	291				1,749	7
8	**TOTAL General Services**	(801)			(7,796)	3,031	326	8,871	(1,024)				2,607	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(325)			(17,825)			16,192					(1,958)	10
10a	Therapy													10a
11	Activities													11
12	Social Services							9,356					9,356	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*						1,426	3,738					5,164	15
16	**TOTAL Health Care and Programs**	(325)			(17,825)		1,426	29,286					12,562	16
	C. General Administration													
17	Administrative							11,815	142				11,957	17
18	Directors Fees													18
19	Professional Services	(66)				(144,388)			15				(144,439)	19
20	Fees, Subscriptions & Promotions	(9,875)	250			2,423			8				(7,194)	20
21	Clerical & General Office Expenses	(269,115)	89			12,688		114,926	257				(141,155)	21
22	Employee Benefits & Payroll Taxes			(970)	(380)		(3,668)						(5,018)	22
23	Inservice Training & Education													23
24	Travel and Seminar					3,452			64				3,516	24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice					704			55				759	26
27	Other (specify):*						1,825	18,389					20,214	27
28	**TOTAL General Administration**	(279,056)	339	(970)	(380)	(125,121)	(1,843)	145,130	541				(261,360)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(280,182)	339	(970)	(26,001)	(122,090)	(91)	183,287	(483)				(246,192)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(59,046)	171,904			12,897				9,326			135,081	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(33,805)	222,085						8	1,041			189,329	32
33	Real Estate Taxes					1,607							1,607	33
34	Rent-Facility & Grounds		(461,356)			4,056			296				(457,004)	34
35	Rent-Equipment & Vehicles					1,560			6				1,566	35
36	Other (specify):*	(31,371)	50,905										19,534	36
37	**TOTAL Ownership**	(124,222)	(16,462)			20,120			310	10,367			(109,887)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers				(8,740)				(2,396)	(19,295)			(30,431)	39
40	Barber and Beauty Shops	(39,025)											(39,025)	40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**	(39,025)			(8,740)				(2,396)	(19,295)			(69,456)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(443,429)	(16,123)	(970)	(34,741)	(101,970)	(91)	183,287	(2,569)	(8,928)			(425,534)	45

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Lemont Property, LLC		Building Co.

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	$ 461,356	Lemont Building LLC	100.00%	$	$ (461,356)	1
2	V	33	Real Estate Tax	252,582	Lemont Building LLC	100.00%	252,582		2
3	V	21	Bank Charges		Lemont Building LLC	100.00%	86	86	3
4	V	20	Filing Fee		Lemont Building LLC	100.00%	250	250	4
5	V	30	Depreciation		Lemont Building LLC	100.00%	171,904	171,904	5
6	V	36	Amortization		Lemont Building LLC	100.00%	50,905	50,905	6
7	V	32	Interest		Lemont Building LLC	100.00%	222,085	222,085	7
8	V	21	State Replacement Tax		Lemont Building LLC	100.00%	3	3	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 713,938			$ 697,815	$ * (16,123)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		22	EMPLOYEE HEALTH INSURANCE	$	CCS EMPLOYEE BENEFIT GROUP	100.00%	$ 178,578	$ 178,578	15
16	V									16
17	V									17
18	V									18
19	V		22	EMPLOYEE HEALTH INSURANCE	179,548	CCS EMPLOYEE BENEFIT GROUP	100.00%		(179,548)	19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 179,548			$ 178,578	$ * (970)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	$ 532	XCEL MEDICAL SUPPLY, LLC	100.00%	$ 453	$ (79)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	37,327	XCEL MEDICAL SUPPLY, LLC	100.00%	31,789	(5,538)	17
18	V	04	LAUNDRY	14,509	XCEL MEDICAL SUPPLY, LLC	100.00%	12,356	(2,153)	18
19	V	06	REPAIRS & MAINTENANCE	179	XCEL MEDICAL SUPPLY, LLC	100.00%	152	(27)	19
20	V	10	NURSING	120,149	XCEL MEDICAL SUPPLY, LLC	100.00%	102,324	(17,825)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22	EMPLOYEE BENEFITS	2,563	XCEL MEDICAL SUPPLY, LLC	100.00%	2,183	(380)	24
25	V	39	ANCILLARY	58,910	XCEL MEDICAL SUPPLY, LLC	100.00%	50,170	(8,740)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 234,169			$ 199,427	$ * (34,741)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$	Care Centers, Inc.	100.00%	$ 341	$ 341	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,301	1,301	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,389	1,389	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	151,392	Care Centers, Inc.	100.00%	7,004	(144,388)	20
21	V	20	Dues and Subscriptions		Care Centers, Inc.	100.00%	2,423	2,423	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	12,688	12,688	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	3,452	3,452	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	704	704	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	12,897	12,897	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	1,607	1,607	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	4,056	4,056	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	1,560	1,560	29
30	V	25	Bus Reimbursement		Care Centers, Inc.	100.00%			30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 151,392			$ 49,422	$ * (101,970)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	$ 2,229	Care Centers, Inc.	100.00%	$ 2,229	$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	326	326	16
17	V	10	Nursing Salary	6,628	Care Centers, Inc.	100.00%	6,628		17
18	V	10a	Rehab Salary	157	Care Centers, Inc.	100.00%	157		18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary	2,963	Care Centers, Inc.	100.00%	2,963		20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	1,426	1,426	21
22	V	17	Administration Salary		Care Centers, Inc.	100.00%			22
23	V	21	Office Salary	12,475	Care Centers, Inc.	100.00%	12,475		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	1,825	1,825	24
25	V	22	Employee Benefits	3,668	Care Centers, Inc.	100.00%		(3,668)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 28,120			$ 28,029	$ * (91)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	$	Care Centers, Inc.	100.00%	$ 3,106	$ 3,106	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	4,633	4,633	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,132	1,132	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	16,192	16,192	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	9,356	9,356	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	3,738	3,738	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	11,815	11,815	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	114,926	114,926	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	18,389	18,389	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 183,287	$ * 183,287	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	$ 7,852	Care Centers, Inc. - Health Systems Division	100.00%	$ 552	$ (7,300)	15
16	V	02	Food		Care Centers, Inc. - Health Systems Division	100.00%	3,975	3,975	16
17	V	06	Maintenance		Care Centers, Inc. - Health Systems Division	100.00%	21	21	17
18	V	17	Administration		Care Centers, Inc. - Health Systems Division	100.00%	142	142	18
19	V	19	Professional Fees		Care Centers, Inc. - Health Systems Division	100.00%	15	15	19
20	V	20	Dues & Subscriptions		Care Centers, Inc. - Health Systems Division	100.00%	8	8	20
21	V	21	Office & Clerical		Care Centers, Inc. - Health Systems Division	100.00%	257	257	21
22	V	24	Travel & Seminar		Care Centers, Inc. - Health Systems Division	100.00%	64	64	22
23	V	26	Insurance		Care Centers, Inc. - Health Systems Division	100.00%	55	55	23
24	V	32	Interest Expense		Care Centers, Inc. - Health Systems Division	100.00%	8	8	24
25	V	34	Rent - Building		Care Centers, Inc. - Health Systems Division	100.00%	296	296	25
26	V	35	Rent - Equipment & Auto		Care Centers, Inc. - Health Systems Division	100.00%	6	6	26
27	V	39	Ancillary Enteral Supplies	4,852	Care Centers, Inc. - Health Systems Division	100.00%	2,456	(2,396)	27
28	V	01	Dietary - Salary		Care Centers, Inc. - Health Systems Division	100.00%	1,989	1,989	28
29	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc. - Health Systems Division	100.00%	291	291	29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 12,704			$ 10,135	$ * (2,569)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		30	Depreciation	$	Vent Lease, LLC.	100.00%	$ 9,326	$ 9,326	15
16	V		32	Interest		Vent Lease, LLC.	100.00%	1,041	1,041	16
17	V		39	Vent Reimbursement	19,295	Vent Lease, LLC.	100.00%		(19,295)	17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 19,295			$ 10,367	$ * (8,928)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Owner	Administrative	1.00%	See Attached	1.10	2.38%	Sal, Fee	$ 7,975	17-03	1
2	Adam Vales	Owner	Clerical	11.00%	See Attached	1.16	2.90%	CCS-VEBA	1,204	22-07	2
3	Mark Steinberg	Relative	Administrative	0%	See Attached	1.58	2.87%	CCI-Salary	2,119	17-07	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 11,298		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847)905-4000
Fax Number: (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURA	DIRECT ALLOCATION			$	$		$ 178,578	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 178,578	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: XCEL MEDICAL SUPPLY, LLC
Street Address: 2201 MAIN STREET
City / State / Zip Code: EVANSTON, IL 60202
Phone Number: (847)328-7600
Fax Number: (847)328-7615

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			$	$		$ 453	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						31,789	3
4	04	LAUNDRY	Direct Allocation						12,356	4
5	06	REPAIRS & MAINTENANCE	Direct Allocation						152	5
6	10	NURSING	Direct Allocation						102,324	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFIC	Direct Allocation							9
10	22	EMPLOYEE BENEFITS	Direct Allocation						2,183	10
11	39	ANCILLARY	Direct Allocation						50,170	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 199,427	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Patient Days	1,484,397	42	$ 9,730	$	52,045	$ 341	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		52,045	1,301	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		52,045	1,389	3
4	10	Nursing	Patient Days	1,484,397	42			52,045		4
5	11	Activities	Patient Days	1,484,397	42			52,045		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		52,045	7,004	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		52,045	2,423	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		52,045	12,688	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		52,045	3,452	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		52,045	704	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		52,045	12,897	11
12	32	Interest	Patient Days	1,484,397	42			52,045		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		52,045	1,607	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		52,045	4,056	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		52,045	1,560	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,409,572	$		$ 49,422	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919		2,229	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757			326	2
3	10	Nursing Salary	Direct Cost			209,584	209,584		6,628	3
4	10a	Rehab Salary	Direct Cost			66,982	66,982		157	4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710		2,963	6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220			1,426	7
8	17	Administration Salary	Direct Cost			38,431	38,431			8
9	21	Office Salary	Direct Cost			525,935	525,935		12,475	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			1,825	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,344,103	$ 1,172,560		$ 28,029	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	52,045	3,106	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			52,045		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	52,045	4,633	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		52,045	1,132	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	52,045	16,192	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			52,045		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	52,045	9,356	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		52,045	3,738	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	52,045	11,815	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	52,045	114,926	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		52,045	18,389	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,227,610	$ 4,564,232		$ 183,287	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Care Centers, Inc.
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 905-3000
Fax Number: (847) 905-3030

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	Dietary	Billable Income	2,144,835		93,149		12,704	552	1
2	02	Food	Billable Income	2,144,835		987,169		12,704	3,975	2
3	06	Maintenance	Billable Income	2,144,835		3,597		12,704	21	3
4	17	Administration	Billable Income	2,144,835		24,000		12,704	142	4
5	19	Professional Fees	Billable Income	2,144,835		2,500		12,704	15	5
6	20	Dues & Subscriptions	Billable Income	2,144,835		1,342		12,704	8	6
7	21	Office & Clerical	Billable Income	2,144,835		43,384		12,704	257	7
8	24	Travel & Seminar	Billable Income	2,144,835		10,755		12,704	64	8
9	26	Insurance	Billable Income	2,144,835		9,262		12,704	55	9
10	32	Interest Expense	Billable Income	2,144,835		1,371		12,704	8	10
11	34	Rent - Building	Billable Income	2,144,835		50,000		12,704	296	11
12	35	Rent - Equipment & Auto	Billable Income	2,144,835		1,080		12,704	6	12
13	39	Ancillary Enteral Supplies	Billable Income	2,144,835		98,519		12,704	2,456	13
14	01	Dietary - Salary	Billable Income	2,144,835		335,801	335,801	12,704	1,989	14
15	07	Emp. Ben. - Gen. Serv.	Billable Income	2,144,835		49,127		12,704	291	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,711,055	$ 335,801		$ 10,135	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Vent Lease, LLC
Street Address: 2201 West Main Street
City / State / Zip Code: Evanston, Illinois 60202
Phone Number: (847) 674-1180
Fax Number: (847) 673-7741

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	Depreciation	Direct Billing	620,670	29	$ 300,000	$	19,295	$ 9,326	1
2	32	Interest	Direct Billing	620,670	29	33,493		19,295	1,041	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 333,493	$		$ 10,367	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LaSalle Bank		X	Mortgage			$	$ 5,361,287			$ 202,394	1
2												2
3												3
4												4
5	See Supplemental Schedule											5
	Working Capital											
6	LaSalle Bank		X	Line of Credit							519	6
7	Genesis (Prior Owners)		X					328,185			19,691	7
8	See Supplemental Schedule							244,472			1,049	8
9	TOTAL Facility Related						$	$ 5,933,944			$ 223,653	9
	B. Non-Facility Related*											
10	Interest Income		X								(33,805)	10
11												11
12												12
13	See Supplemental Schedule											13
14	TOTAL Non-Facility Related						$	$			$ (33,805)	14
15	TOTALS (line 9+line14)						$	$ 5,933,944			$ 189,848	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 0 Line # n/a

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
6												6
7	TOTAL Long-Term											7
	Working Capital											
8	Shareholder	X					$	$ 244,472			$	8
9	Allocate Care Centers		X								8	9
10	Allocate Vent Lease		X								1,041	10
11												11
12												12
13												13
14	TOTAL Working Capital							244,472			1,049	14
	B. Non-Facility Related*											
15							$	$			$	15
16												16
17												17
18												18
19												19
20	TOTAL Non-Facility Related											20

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	258,163	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	250,751	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,412)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	261,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	254,188	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	266,255	8
	2000	268,724	9
	2001	273,267	10
	2002	245,866	11
	2003	249,144	12

2004 Accrual - $249,144 X 1.05 = $261,600

Allocation From Care Centers - $1,607

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	22-27-300-048-0000	Long Term Care Property	$ 249,143.70	$ 249,143.70
2.	See Attached	Home Office	$ 45,838.00	$ 1,607.14
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 294,981.70	$ 250,750.84

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lemont Nursing & Rehab Center, Llc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0046201

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847)236-1111 FAX #: (847)236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Brick Frame Masonry & Steel Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		2003	$ 823,094	1
2	Allocation From 2201 Main LLC			12,331	2
3	TOTALS			$ 835,425	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9								-		-	9
10								-		-	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		4,167,965	106,871		104,199	(2,672)	199,715	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		47,573	1,954		1,954		4,058	68
69	Financial Statement Depreciation			20,061			(20,061)		69
70	TOTAL (lines 4 thru 69)		$ 4,215,538	$ 128,886		$ 106,153	$ (22,733)	$ 203,773	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,215,538	$ 128,886		$ 106,153	$ (22,733)	$ 203,773	1
2	Avary	2003	4,987		20	997	997	1,912	2
3	Cooler Repair	2003	522		20	26	26	50	3
4	Air Conditioner Repair	2003	985		20	49	49	94	4
5	Sewer Rodding	2003	725		20	36	36	60	5
6	Sewer Maintenance	2003	640		20	32	32	53	6
7	Floor Tile Replacement	2003	508		20	25	25	40	7
8	Lunchroom Door Repair	2003	852		20	43	43	67	8
9	Parking Lot Lights	2003	1,290		20	65	65	102	9
10	Keypad Alarm	2003	547		20	78	78	117	10
11	Hot Water Repair	2003	950		20	48	48	67	11
12	Walk In Cooler - Compressor Repair	2003	1,450		20	73	73	103	12
13	Light Pole Repairs	2003	2,959		20	148	148	210	13
14	Light Pole Repairs	2003	1,090		20	55	55	77	14
15	Generator Repair	2003	859		20	43	43	57	15
16	Check Hot Water System	2003	937		20	47	47	62	16
17	State Required Backflow Test	2003	930		20	47	47	62	17
18	Insurance Proceeds	2003	(1,050)		20	(53)	(53)	(70)	18
19	Door Keypads & Sounder Install	2003	2,226		20	318	318	424	19
20	Toilet Bowls With Accessories	2003	631		20	32	32	39	20
21	Water Heater Repair	2003	504		20	25	25	32	21
22	Electrical Work	2003	2,545		20	127	127	159	22
23	Electrical Vestibule Doors	2003	7,060		20	353	353	441	23
24	Flash To Field Or Wall Flashings	2003	800		20	40	40	50	24
25	Keypads & Doorsite Sounders	2003	6,679		20	334	334	417	25
26	Deposit On Above	2003	(2,226)		20	(111)	(111)	(139)	26
27	Speakman Valve Group	2003	710		20	35	35	41	27
28	Roton Hinge	2003	609		20	30	30	36	28
29	Rewire Feeds For Ceiling Lights	2003	630		20	32	32	37	29
30	Service On Fire Alarm Control Panel	2003	1,234		20	62	62	72	30
31	Install Softener System	2003	2,946		20	147	147	172	31
32	Adjust Rooms With Hot Water Problem	2003	930		20	46	46	54	32
33	2Nd Floor Dining Room Heat Problem	2003	653		20	33	33	38	33
34	TOTAL (lines 1 thru 33)		$ 4,260,650	$ 128,886		$ 109,415	$ (19,471)	$ 208,709	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,260,650	$ 128,886		$ 109,415	$ (19,471)	$ 208,709	1
2	Replace Pipe	2003	633		20	32	32	37	2
3	Repair 4 Mainonnorthdrysystem"	2003	625		20	31	31	36	3
4	Fire Alarm Repair	2003	966		20	48	48	89	4
5	Fire Alarm Pipe	2003	820		20	41	41	72	5
6	Fire Alarm Control Panel	2003	508		20	25	25	42	6
7	Ceiling Tile	2004	1,702		20	312	312	312	7
8	Sprinkler Replacement	2004	4,835		20	141	141	141	8
9	Ceiling Repair	2004	6,150		20	128	128	128	9
10	Water Heater	2004	4,347		20	362	362	362	10
11	Hp Bronze Pump	2004	1,739		20	348	348	348	11
12	New Carpeting	2004	7,838		20	98	98	98	12
13	Painting	2004	6,500		20	54	54	54	13
14	Call Cords	2004	2,055		20	24	24	24	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 4,299,368	$ 128,886		$ 111,059	$ (17,827)	$ 210,452	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	158		2003		$ 4,167,965	$ 106,871		$ 104,199	$ (2,672)	$ 199,715	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,167,965	$ 106,871		$ 104,199	$ (2,672)	$ 199,715	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	2201 Main LLC Allocation		2002		$ 16,993	$ 425		$ 425	$	$ 1,062	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	2201 Main LLC Allocation			2002	14,037	702	20	702		1,755	9
10	2201 Main LLC Allocation			2003	16,543	827	20	827		1,241	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 47,573	$ 1,954		$ 1,954	$	$ 4,058	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 284,007	$ 78,442	$ 28,846	$ (49,596)	10	$ 89,895	71
72	Current Year Purchases	91,265	5,065	13,442	8,377	10	13,442	72
73	Fully Depreciated Assets	9,944				10	9,944	73
74								74
75	TOTALS	$ 385,216	$ 83,507	$ 42,288	$ (41,219)		$ 113,281	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Care Centers Allocation		2004	$ 23,948	$ 1,742	$ 1,742	$	5	$ 20,167	76
77	Care Centers Allocation		2004	365	55	55		5	55	77
78										78
79										79
80	TOTALS			$ 24,313	$ 1,797	$ 1,797	$		$ 20,222	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 5,544,322	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 214,190	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 155,144	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (59,046)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 343,955	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Expansion Work	$ 8,250	92
93			93
94			94
95		$ 8,250	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Storage				4,388			5
6	Allocate Care Centers				4,352			6
7	TOTAL				$ 8,740 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 10,610 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 59,231	$		$ 59,231	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			26,191			26,191	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			744,112			744,112	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				451,472		451,472	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental					1,580	155,984		157,564	13
14	TOTAL			$		$ 831,114	$ 607,456		$ 1,438,570	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 11,206	$ 63,797	1
2	Cash-Patient Deposits	6,017	6,017	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,742,401	1,742,401	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	21,410	21,410	6
7	Other Prepaid Expenses	6,521	31,521	7
8	Accounts Receivable (owners or related parties)	497,850	222,462	8
9	Other(specify): See Attached Schedule	1,518,936	1,659,508	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,804,341	$ 3,747,116	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		823,094	13
14	Buildings, at Historical Cost		5,391,421	14
15	Leasehold Improvements, at Historical Cost	44,143	44,143	15
16	Equipment, at Historical Cost	125,356	324,439	16
17	Accumulated Depreciation (book methods)	(33,791)	(394,526)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		13,085	19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		55,394	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 135,708	$ 6,257,050	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,940,049	$ 10,004,166	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 890,955	$ 890,957	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,402	5,402	28
29	Short-Term Notes Payable		572,657	29
30	Accrued Salaries Payable	202,400	202,400	30
31	Accrued Taxes Payable (excluding real estate taxes)	9,622	9,622	31
32	Accrued Real Estate Taxes(Sch.IX-B)	261,600	261,600	32
33	Accrued Interest Payable		13,346	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule	107,252	111,734	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,477,231	$ 2,067,718	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		5,361,287	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 5,361,287	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,477,231	$ 7,429,005	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,462,818	$ 2,575,161	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,940,049	$ 10,004,166	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,137,649	1
2	Restatements (describe):		2
3	See Attached	265,983	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,403,632	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,151,403	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(92,217)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,059,186	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,462,818	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 9,986,530	1
2	Discounts and Allowances for all Levels	(4,079,404)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,907,126	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	3,631,902	6
7	Oxygen	1,809	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,633,711	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	30,211	13
14	Non-Patient Meals	185	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	454,755	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	106,613	19
20	Radiology and X-Ray	33,670	20
21	Other Medical Services	185,573	21
22	Laundry	3,315	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 814,322	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	33,805	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 33,805	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Supplemental Schedule	75	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 75	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 10,389,039	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,270,766	31
32	Health Care	4,008,289	32
33	General Administration	1,646,296	33
	B. Capital Expense		
34	Ownership	747,948	34
	C. Ancillary Expense		
35	Special Cost Centers	1,477,595	35
36	Provider Participation Fee	86,742	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 9,237,636	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,151,403	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,151,403	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Not Complete **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,999	2,249	$ 73,324	$ 32.60	1
2	Assistant Director of Nursing	1,971	2,186	60,001	27.45	2
3	Registered Nurses	25,463	28,716	848,692	29.55	3
4	Licensed Practical Nurses	25,156	27,403	631,288	23.04	4
5	Nurse Aides & Orderlies	107,301	117,627	1,371,028	11.66	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,387	7,228	115,045	15.92	8
9	Activity Director	2,398	2,741	46,958	17.13	9
10	Activity Assistants	10,140	10,787	97,941	9.08	10
11	Social Service Workers	7,984	8,861	146,183	16.50	11
12	Dietician					12
13	Food Service Supervisor	2,065	2,317	62,215	26.85	13
14	Head Cook					14
15	Cook Helpers/Assistants	21,467	24,524	224,870	9.17	15
16	Dishwashers					16
17	Maintenance Workers	6,445	6,947	116,952	16.83	17
18	Housekeepers	14,545	16,058	133,736	8.33	18
19	Laundry	6,564	7,005	56,014	8.00	19
20	Administrator	1,981	2,152	86,057	39.99	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,771	4,022	92,546	23.01	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,928	2,331	29,552	12.68	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	247,565	273,154	$ 4,192,402 *	$ 15.35	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	283	$ 12,076	01-03	35
36	Medical Director	Monthly	35,000	09-03	36
37	Medical Records Consultant	Monthly	1,876	10-03	37
38	Nurse Consultant	5	254	10-03	38
39	Pharmacist Consultant	Monthly	4,768	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,173	11-03	44
45	Social Service Consultant	25	1,377	12-03	45
46	Other(specify)				46
47	Dental Consultant	Monthly	2,475	10-03	47
48	See Attached - CCI Consultants		9,748	Various	48
49	TOTAL (lines 35 - 48)	358	$ 69,747		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	4,678	$ 225,668	10-03	50
51	Licensed Practical Nurses	2,538	98,797	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	7,216	$ 324,465		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Francisco Guajardo	Administrator	0	$ 86,057
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 86,057

B. Administrative - Other

Description	Amount
Management Fees-Eric Rothner	$ 7,975
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 7,975

C. Professional Services

Vendor/Payee	Type	Amount
See Attached	Legal	$ 71,199
FR&R	Accounting	10,000
See Attached	Computer Services	28,158
Care Centers, Inc.	Other Professional	5,400
Sue Bruzan	Medicare Consultant	175
Joseph Abramchick	AR Consultant	1,333
Care Centers, Inc.	Bookkeeping	32,232
Care Centers, Inc.	Home Office	113,760
TBT Enterprises	Unemployment Consult	1,267
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 263,524

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 162,995
Unemployment Compensation Insurance	86,575
FICA Taxes	306,514
Employee Health Insurance	77,573
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	4,596
Other Employee Welfare	2,124
Holiday Expense	5,797
TOTAL (agree to Schedule V, line 22, col.8)	$ 646,174

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 2,576
Advertising: Employee Recruitment	14,547
Health Care Worker Background Check	2,118
(Indicate # of checks performed 169)	
Dues and Subscriptions	1,106
Licenses	580
Allocate Care Centers	2,431
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,358

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,297
Allocate Care Centers	3,516
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,813

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc # 0046201 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lemont Nursing & Rehab Center, Llc **#** 0046201 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **98,835** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **86,742**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **185**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.